LEON COUNTY SCHOOLS

DIABETES MEDICAL MANAGEMENT PLAN & NURSING CARE PLAN

School Year: 2021- 2022

Plan Effective Date(s): _____

☐ **TMH Telemedicine consent completed**

Student's Name: _____ Date of Birth:_____

Date of Diabetes Diagnosis: _____ ☐Type 1 ☐Type 2 School Nurse: _____

School Name: _____ School phone number: _____

Grade: _____ Homeroom: _____ **Independent Management of Diabetes ☐ Yes ☐ No**

CONTACT INFORMATION

Parent/Guardian #1: _____ Preferred Contact number: _____ ALT: _____

Parent/Guardian #2:_____ Preferred Contact number: _____ ALT: _____

Other Emergency Contact: _____Relationship: _____ Phone Number:_____ ALT: _____

Diabetes Healthcare Provider:_____ Phone Number: (850)_____

Diabetes Educator: _____ Phone Number: (850)_____

MEAL PLAN TYPE: ☐ Insulin to Carb Ratio ☐ Consistent Carbohydrate: Meal Range: _____grams to _____grams

Student's self-care nutrition skills: Snack Range: _____grams to _____grams

☐ Independently counts carbohydrates ☐ May count carbohydrates with supervision

☐ Requires school nurse/UAP diabetes personnel to count carbohydrates

Meal Plan (meals/snacks child to have):

"X" To Select	Meal	Time
	Breakfast	
	Mid-morning snack	

"X" To Select	Meal	Time
	Lunch	
	Mid-afternoon snack	

Instructions for when food is provided to the class (e.g., as part of class party or other event): **Notify parent/guardian of party in advance to provide an alternate drink option**._____

BLOOD GLUCOSE MONITORING AT SCHOOL:

☐ **Yes** ☐ **No**

☐ School personnel not responsible for testing/monitoring, **but supplies are to be available**

☐ **Blood Glucose test to be performed in school clinic**

☐ In addition to school clinic, may test outside of clinic

Student's self-care blood glucose checking skills:

☐ **Independently checks own blood glucose** ☐ **May check blood glucose with supervision**

☐ **Requires school nurse/UAP diabetes personnel to check blood glucose**

☐ Uses a CGM (continuous glucose monitor) - **See CGM addendum**

☐ Independently treats hypoglycemia outside of clinic

Time(s) for Glucose monitoring to be performed:

☐ Before breakfast

☐ Midmorning: before snack

☐ Before Lunch

☐ Mid-afternoon

☐ After PE/Activity Time

☒ As needed for signs/symptoms of low/high blood Glucose

☐ 2-hours after a correction bolus

☐ Before Dismissal, give snack if **≤ 100mg/dL**

☐ Before PE/Activity Time **(give snack if < _____mg/dL to bring blood glucose to ≥ 100mg/dL)**

☐ Other:

_____

Name:_____ **Date of Birth:** _____

INSULIN ADMINISTRATION

INSULIN ADMINISTRATION DURING SCHOOL: ☐ School personnel **not** responsible for the administration of insulin

Insulin Delivery: ☐ Pen ☐ Pump **(See Pump Addendum)**

Long Acting Insulin administration at school: Lantus/Tresiba/Basaglar/Levemir ☐ Yes ☐ No

If Yes: Insulin Dose: _____Time: _____

Rapid acting: Novolog/Humalog/Admelog ☐ Yes ☐ No

Time to be given: ☐ Breakfast (☐Before ☐After); ☐ Lunch (☐Before ☐After); ☐ With Snack ☐AM ☐PM ☐ Other

****If "before" meal is selected and blood glucose is ≤ 100mg/dL or unsure if child will finish all of the meal, may give after meal****

Insulin Dosing: ☐ Carbohydrate ratio ☐ Correction Factor ☐ Sliding scale ☐ Fixed insulin Dose ☐ Per pump settings

Student's self-care insulin administration skills:

☐ Independently calculates and gives own dose ☐ May calculate/give own dose with supervision

☐ Requires school nurse or UAP to calculate and student can give own dose with supervision

☐ Requires school nurse or UAP to calculate dose and give dose

CORRECTION FACTOR: 1unit of insulin for every ____ points that blood glucose is above or below target of _____mg/dL

Note: If pre-meal BG is less than target, the amount calculated for total insulin will be less than the amount calculated for food (carb) intake.

Add correction dose to carbohydrate dose at meals:

☐ Breakfast ☐ Lunch

Correction Example

$$\frac{Current\ BG - Target\ BG}{Correction\ Factor} = \_\_\_Units\ of\ Insulin$$

CARBOHYDRATE (carbs) RATIO:

☐ Breakfast: 1 unit of insulin per _____ grams of carbs consumed

☐ AM Snack: 1 unit of insulin per _____ grams of carbs consumed

☐ Lunch: 1 unit of insulin per _____ grams of carbs consumed

☐ PM Snack: 1 unit of insulin per _____ grams of carbs consumed

☐ Miscellaneous food/snack/party: 1 unit of insulin per _____ grams of carbs consumed

Carbohydrate Example

$$\frac{Grams\ of\ Carb\ to\ be\ eaten}{Insulin\ to\ Carb\ Ratio} = \_\_\_Units\ of\ Insulin$$

SLIDING SCALE:

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

Blood sugar: _____- _____ Insulin Dose: _____

FIXED INSULIN DOSE:(i.e. student is on predetermined number of units at prescribed time(s))

Type of insulin:	**Dose:**	**Time to be given**:

PARENTS/GUARDIANS AUTHORIZATION TO ADJUST INSULIN DOSE

******Must be AUTHORIZED by healthcare provider AND Parents wishing to make changes are to contact the School's Registered Nurse******

☐ Yes ☐ No: Parents/guardians authorization should be obtained before administering a correction dose for hyperglycemia outside of mealtime

☐ Yes ☐ No: Parents/guardians are authorized to increase or decrease correction factor within the following range: **+/-** _____ points that the blood glucose is above/below target blood glucose

☐ Yes ☐ No: Parents/guardians are authorized to increase or decrease carb ratio within the following range: 1 unit per prescribed grams of carb. **+/-** _____ grams of carb

☐ Yes ☐ No: Parents/guardians are authorized to increase or decrease fixed insulin dose within the following range: **+/-** _____ units of insulin

Name:_____ **Date of Birth:** _____

MANAGEMENT OF HYPERGLYCEMIA (HIGH) BLOOD GLUCOSE (over _300_ mg/dl)

Typical Signs/Symptoms of Hyperglycemia:

- Increased thirst, urination, appetite
- Tiredness/sleepiness
- Blurred vision
- Warm, dry, or flushed skin
- Other: _____

Emergency Hyperglycemia Signs/Symptoms:

- Nausea and/or vomiting
- Rapid, shallow breathing
- Fruity breath
- Severe abdominal pain
- Increased sleepiness/lethargy
- Depressed level of consciousness

Provide the following treatment:

- Give extra water and/or sugar-free fluids as tolerated
- Use Insulin correction factor/dose when blood sugar is over **300 and it has been 2 hours since last insulin, *CALL SCHOOL RN FIRST***
- Frequent bathroom privileges
- Check urine ketones if blood glucose over **300** mg/dl
- Return to clinic in 1 hour to recheck blood glucose if ketones trace or lower.
- CALL parents if ketones are more than trace.

If ketones are trace or lower it is not necessary for student to go home or to be kept in the clinic.

When ketones of small or greater are present:

- Stay with student and document changes in status.
- Call parent. If unable to reach parent, call School RN for appropriate instruction and/or contact of diabetes care provider.
- Student should be sent home.

MANAGEMENT OF HYPOGLYCEMIA (LOW) BLOOD GLUCOSE (below ____70___ mg/dl)

Mild to Moderate		Severe
• Shaky or Jittery • Clammy/Sweaty • Hungry • Pale • Headache • Blurry vision	• Weak/Tired/Lethargic • Inattention/Confused/Disoriented • Dizziness/Staggering • Argumentative/Combative • Change in personality or behavior	• Slurred speech • Inability to eat or drink • Unconscious • Unresponsive • Seizure activity or convulsions (jerking movements)

Usual symptoms for this student: _____

Treatment for Mild to Moderate Hypoglycemia

- Test Blood Glucose (BG)
- Give **15 grams** fast-acting carbohydrate such as:
  - **3-4 glucose tablets (preferred)**
  - 2-3 rolls of smarties
  - Gummies
  - 4oz. Fruit juice or non-diet soda
  - Concentrated glucose gel or tube gel (for child with trouble swallowing)
  - 8oz. of 1% or fat-free Milk
  - Other: _____
- **IF BG is ≤ 50 mg/dL** = give student with **30 grams** of fast acting carbs
- **Retest BG** 15 minutes after treatment
- Repeat treatment until blood glucose over 80 mg/dL
- **Follow treatment with snack of 15g with protein** (i.e. cheese OR peanut butter crackers) **if it will be more than 1 hour until next meal/snack or if going to activity**
- Other: _____

Treatment for Severe Hypoglycemia

- Administer glucose gel if student is awake but unable to drink or eat.

If student is unconscious or having a seizure, presume the student has low blood glucose and:

- Trained personnel administer: **(Circle ONE)**
  - Glucagon**:**
    < 9 years old ½ mg
    ≥ 9 years old 1mg
  - BAQSIMI (3mg) spray in one nostril
  - Administer Gvoke (subcutaneous injection)
    < 11 years old ½ mg
    ≥ 12 years old 1mg
- While treating, have another person call 911.
- Position student on his or her side and maintain this position until recovered from episode.
- Contact student's parent/guardian.
- Stay with student until Emergency Medical Services arrive.
- Notify EMS if student on insulin pump

Name:_____ **Date of Birth:** _____

SUPPLIES MUST BE PROVIDED BY PARENT/GUARDIAN AND RESTOCKED THROUGHOUT THE SCHOOL YEAR: (Agreed upon locations noted on emergency card/action plan)

- ✓ Blood glucose meter, strips, lancets, lancing device
- ✓ Glucose Gel &/or Cake Gel Tube
- ✓ Insulin pen/pen needles/cartridges
- ✓ Other fast-acting carbohydrates (Smarties, gummies, glucose tabs, juice)
- ✓ Ketone testing strips
- ✓ Glucagon Emergency Kit
- ✓ Other carbohydrate & protein snack:(i.e. peanut butter/cheese crackers, granola bars)

PHYSICAL ACTIVITY, **SPORTS, and EMERGENT SITUATIONS (i.e. lockdown, fire, etc.)**

****Quick access to water, fast-acting carbohydrate (glucose tabs, Smarties, gummies, gel), and monitoring equipment is always recommended to be available. ****

SIGNATURES

I/we understand that all treatments and procedures may be performed by the student and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this information sheet and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

Parent's Signature (Required):_____ Date: _____

Physician's Signature (Required): _____ Date: _____

School Nurse's Signature (Required): _____ Date: _____

For School Personnel Completion:
The following personnel are trained to provide care:
_____

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(School Year: 2021- 2022) Plan Effective Date(s): _____

Continuous Glucose Monitor (CGM) Addendum

Student's Name: _____ Date of Birth: _____

CGM Brand/Model:_____

The student should be escorted to the nurse/aid if the CGM alarm goes off:

☐ **Yes** ☐ **No** ☐ **Only when sensor is reading LOW or ≥ 350 md/dL**

ADDITIONAL INFORMATION FOR STUDENT WITH CGM (CONTINUOUS GLUCOSE MONITOR)**:**

- Insulin injections should be given at least three inches away from the CGM insertion site.
- Do not disconnect from the CGM for sports/activities.
- If the adhesive is peeling, reinforce with approved medical tape.
- If the CGM becomes dislodged, return everything to the parent/guardian. DO NOT throw any part away.
- All CGMs are waterproof, excluding receiver.

CGMs contain three parts:

- **Glucose sensor**: Placed under the skin by the user with an inserter. The electrode that is placed under the skin measures interstitial fluids and the changes in the user's glucose.
- **Transmitter**: Sends the information from the sensor to the device it is connected to.
- **Receiver**: Shows the results obtained by the sensor. This may also be a smart device (phone) or an insulin pump

☐ Guidelines for *Dexcom G6 CGM* :

- Mealtime and/or correction dosing? **YES**
  - G6 sensor values may be used in place of finger-stick.
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.
- If CGM reading is "LO" or "HI", check glucose via finger-stick.
- The sensor glucose reading does not have any arrows with it then the CGM is not measuring correctly and the sensor data cannot be used to dose insulin at that moment and will need to use finger stick until arrows re-appear.
- If student reports that he/she feels low then the sensor reading may be used to make treatment decisions: follow DMMP orders.
- When treating hypoglycemia follow rule of 15 as described in the DMMP. If at the 15 min. recheck, the sensor value is below 70 mg/dL confirm with a finger-stick prior to treating with another 15 grams of fast acting glucose.
- "Urgent Low Soon Alert" will alert when the G6 predicts that the student's glucose will be 55mg/dL within 20 minutes. Treat with 15g of fast acting carbohydrate and recheck CGM in 15min.

☐ *Guidelines for Medtronic Guardian* CGM

- Mealtime and/or correction dosing? **NO**
  - Guardian CGM value is not FDA approved to dose insulin for meals
- Do not make therapy decisions based on sensor glucose.
- Students should check their BGs prior to meals and calibrate their sensor. Calibrating the sensor is performing a finger-stick and using that blood glucose value to update the device. It's best to calibrate the sensor 3-4 times a day, like before meals and bedtime. So while at school, it's reasonable a student might calibrate once before lunch and/or if the device asks for a calibration
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.

Name:_____ **Date of Birth:** _____

☐ ***Guidelines for Freestyle Libre CGM:***

- Mealtime and/or correction dosing? **YES**
  - Libre sensor values may be used in place of finger-stick.
- When you see the  symbol, you must check your blood glucose with a blood glucose meter before making any treatment decisions. Sensor readings may not accurately reflect blood glucose levels.
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.
- During the first hours after insertion of a Sensor, Sensor readings will be accompanied by the  symbol. Whenever  is displayed, a blood glucose test should be performed to confirm the Sensor reading prior to treatment.
- There are NO alarms or alerts unless you scan the Sensor.
- Must scan sensor at least every 8 hours

☐ ***Guidelines for Freestyle Libre 2 CGM :***

- Mealtime and/or correction dosing? **YES**
  - Libre sensor values may be used in place of finger-stick.
- When you see the  symbol, you must check your blood glucose with a blood glucose meter before making any treatment decisions. Sensor readings may not accurately reflect blood glucose levels.
- If at any time the student's symptoms do not match the CGM reading, confirm glucose via finger-stick.
- During the first 12 hours after insertion of a Sensor, Sensor readings will be accompanied by the  symbol. Whenever  is displayed, a blood glucose test should be performed to confirm the Sensor reading prior to treatment.
- When treating hypoglycemia follow rule of 15 as described in the DMMP. If at the 15 min. recheck, the sensor value is below 70 mg/dL confirm with a finger-stick prior to treating with another 15 grams of fast acting glucose.
- Sensor reader need to be within 20 feet of the student for alerts/alarms to be used.
- Must scan sensor at least every 8 hours.

SIGNATURES

Parent's Signature (Required):_____**Date:** _____

Diabetes Care Provider Signature (Required): _____**Date:** _____

School Nurse's Signature (Required): _____**Date:** _____

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ADDENDUM - FOR STUDENTS WITH INSULIN PUMP

Student's Name: _____ Date of Birth: _____

Brand/Model of pump: _____

☐ If student is using CGM technology, he/she may suspend pump or set temporary basal rate, if blood glucose is trending low, and resume insulin when blood glucose trends up.

Physical Activity

May disconnect from pump for sports activities: ☐ YES, for up to _____ minutes ☐ NO

Set a temporary basal rate: ☐ YES, ____% temporary basal for _____ minutes ☐ NO

Suspend pump use: ☐ YES, for up to _____ minutes ☐ NO

Student's Self-Care Pump Skills	Independent	
Counts carbohydrates	☐ Yes	☐ No
Calculates correct amount of insulin for carbohydrates consumed	☐ Yes	☐ No
Administers correction bolus	☐ Yes	☐ No
Calculates and sets basal profiles	☐ Yes	☐ No
Calculates and sets temporary basal rate	☐ Yes	☐ No
Changes batteries / Charge Pump	☐ Yes	☐ No
Disconnects pump	☐ Yes	☐ No
Reconnects pump to infusion set	☐ Yes	☐ No
Prepares reservoir, cartridge, pod, and/or tubing	☐ Yes	☐ No
Inserts infusion set	☐ Yes	☐ No
Troubleshoots alerts and alarms	☐ Yes	☐ No
Give injection with pen/syringe if needed **and** pen/syringe available	☐ Yes	☐ No
Suspend pump	☐ Yes	☐ No

Supplies to be furnished by parent(s)/guardian(s) based upon the *Student's Self-Care Pump Skills*:

☐ Infusion set/reservoir/cartridge ☐ Batteries/charger ☐ Rapid acting insulin pen or syringe to administer injection

SIGNATURES

Parent's Signature (Required): _____ **Date:** _____

Diabetes Care Provider Signature (Required): _____ **Date:** _____

School Nurse's Signature (Required): _____ **Date:** _____